		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042663

Facility Name: SunBridge Care & Rehab-Effingham

Address: 1115 N. Wenthe (Number) Effingham (City) 62401 (Zip Code)

County: Effingham

Telephone Number: (217) 347-7121 **Fax #** (217) 347-5605

IDPA ID Number: 85-0370802033

Date of Initial License for Current Owners: 6/5/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	XX	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		XX	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Robert Rael **Telephone Number:** (505) 468-2467

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 3/30/01 (Date)
(Type or Print Name) Dean Kiklis
(Title) VP of Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: No Bed Changes

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,234	10,821	3,964	35,019	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,234	10,821	3,964	35,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.73%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/1/97

J. Was the facility purchased or leased after January 1, 1978?
YES [XX] Date 6/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,835

Medicare Intermediary: Blue Cross/Blue Shield of Texas

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	99,207	10,388	12,031	121,626	31,189	152,815	(752)	152,063			1
2	Food Purchase		127,036		127,036		127,036	(196)	126,840			2
3	Housekeeping	66,428	10,137	4	76,569	4,785	81,354		81,354			3
4	Laundry	32,200	13,453	321	45,974	2,320	48,294		48,294			4
5	Heat and Other Utilities			90,136	90,136		90,136	712	90,848			5
6	Maintenance	28,379	11,168	29,188	68,735	2,044	70,779	379	71,158			6
7	Other (specify):*											7
8	**TOTAL General Services**	226,214	172,182	131,680	530,076	40,338	570,414	143	570,557			8
	B. Health Care and Programs											
9	Medical Director			11,100	11,100		11,100		11,100			9
10	Nursing and Medical Records	943,475	169,998	105,613	1,219,086	95,764	1,314,850		1,314,850			10
10a	Therapy		19,661	199,959	219,620		219,620		219,620			10a
11	Activities	37,740	2,469		40,209	2,719	42,928		42,928			11
12	Social Services	36,207		19,054	55,261	2,608	57,869		57,869			12
13	Nurse Aide Training											13
14	Program Transportation							11	11			14
15	Other (specify):*			600	600		600		600			15
16	**TOTAL Health Care and Programs**	1,017,422	192,128	336,326	1,545,876	101,091	1,646,967	11	1,646,978			16
	C. General Administration											
17	Administrative	51,429		189,183	240,612	(64,038)	176,574	(104,579)	71,995			17
18	Directors Fees											18
19	Professional Services			523	523	56	579	9,753	10,332			19
20	Dues, Fees, Subscriptions & Promotions			9,398	9,398	312	9,710	(310)	9,400			20
21	Clerical & General Office Expenses	84,570	6,059	32,224	122,853	13,869	136,722	57,312	194,034			21
22	Employee Benefits & Payroll Taxes			396,786	396,786	(99,383)	297,403	(53,735)	243,668			22
23	Inservice Training & Education			147	147	144	291		291			23
24	Travel and Seminar			6,253	6,253	7,604	13,857	3,810	17,667			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			45,900	45,900		45,900	(35,555)	10,345			26
27	Other (specify):*			17,198	17,198		17,198	(12,740)	4,458			27
28	**TOTAL General Administration**	135,999	6,059	697,612	839,670	(141,436)	698,234	(136,044)	562,190			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,379,635	370,369	1,165,618	2,915,622	(7)	2,915,615	(135,890)	2,779,725			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SunBridge Care & Rehab-Effingham #0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,372	3,372		3,372	18,521	21,893			30
31	Amortization of Pre-Op. & Org.							6,531	6,531			31
32	Interest			287,880	287,880		287,880	(275,788)	12,092			32
33	Real Estate Taxes			26,520	26,520		26,520	334	26,854			33
34	Rent-Facility & Grounds			435,641	435,641		435,641	2,360	438,001			34
35	Rent-Equipment & Vehicles			23,263	23,263	7	23,270	3,471	26,741			35
36	Other (specify):*							7,478	7,478			36
37	**TOTAL Ownership**			776,676	776,676	7	776,683	(237,093)	539,590			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,034	1,034		1,034		1,034			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,880	74,880		74,880		74,880			42
43	Other (specify):*			2,901	2,901		2,901		2,901			43
44	**TOTAL Special Cost Centers**			78,815	78,815		78,815		78,815			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,379,635	370,369	2,021,109	3,771,113		3,771,113	(372,983)	3,398,130			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(61)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(196)	2		13
14	Non-Care Related Interest	(114)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(210)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,453)	27		24
25	Fund Raising, Advertising and Promotional	(287)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(377,285)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (390,606)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	17,623	SCH VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 17,623		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (372,983)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

SunBridge Care & Rehab-Effingham

ID# 0042663

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Meals	$		1
2	Rental Income			2
3	Personal Laundry Income			3
4	Rebates & Refunds			4
5	Sales Tax on food			5
6	Interest expense			6
7	Penalties and Late Fees			7
8	Contributions			8
9	Legal Services (Collection Fees)			9
10	Bad Debt Expense			10
11	Public Relations			11
12	Vending Machine Commission	(752)	1	12
13	Adjust Physical Therapy cost to actual			13
14	Management Fee Expense (IC00)			14
15	Chamber of Commerce	(300)	20	15
16	Regional Public Relations	(210)	20	16
17	Royalty Fees (IC00)			17
18	Other Non-Oper Inc			18
19	Regional Marketing Director	(13,173)	21	19
20	Expense Minor Durable Equipment			20
21	Expense Minor Durable Equipment			21
22	Franchise\Intangible T	(517)	21	22
23	Expense Minor Durable Equipment			23
24	Resident Expenses			24
25	Adj LHI Depr Expense to actual	4,897	30	25
26	Adj equipment Depr Expense to actual	13,624	30	26
27	Depr Exp Minor Durable Equipment			27
28	Barber\Beauty Inc			28
29	Patient Personal Services			29
30	Pat Personal Svcs Inc			30
31	Incontttinency Income			31
32	Equip Rental Income			32
33	Community Awareness			33
34	Special Events			34
35	Miscellaneous Exp (IC00)			35
36	Depr - Equipment (IC00)			36
37	Interest Expense - Interco (IC00)	(282,302)	32	37
38	FAS 121 Charge			38
39	Interest Expense - Net Assets			39
40	PTO Accrual Adjustment	(6,902)	22	40
41	Health Insurance Adjustment	(56,565)	22	41
42	Worker's Compensation Audit Adjustment			42
43	Worker's Compensation Adjustment	2,070	22	43
44	Professional & General Liability Insurance Adjustment	(37,155)	26	44
45	Property Insurance Adjustment			45
46	Auto Insurance Adjustment			46
47				47
48				48
49				49
50				50
51				51
52				52
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80				80
81				81
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(377,285)		90

Sch V	Adj. Summary
Line 1	(752)
Line 2	(196)
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	(948)
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	(210)
Line 20	(510)
Line 21	(13,751)
Line 22	(61,397)
Line 23	0
Line 24	0
Line 25	0
Line 26	(37,155)
Line 27	(12,740)
Line 28	(125,763)
Line 29	(126,711)
Line 30	18,521
Line 31	0
Line 32	(282,416)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(263,895)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(390,606)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(752)	0	0	0	0	0	0	0	0	0	0	(752)	1
2	Food Purchase	(196)	0	0	0	0	0	0	0	0	0	0	(196)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	712	0	0	0	0	0	0	0	0	0	712	5
6	Maintenance	0	379	0	0	0	0	0	0	0	0	0	379	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(948)	1,091	0	0	0	0	0	0	0	0	0	143	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	11	0	0	0	0	0	0	0	0	0	11	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	11	0	0	0	0	0	0	0	0	0	11	16
	C. General Administration													
17	Administrative	0	(104,579)	0	0	0	0	0	0	0	0	0	(104,579)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(210)	9,963	0	0	0	0	0	0	0	0	0	9,753	19
20	Fees, Subscriptions & Promotions	(510)	200	0	0	0	0	0	0	0	0	0	(310)	20
21	Clerical & General Office Expenses	(13,751)	71,063	0	0	0	0	0	0	0	0	0	57,312	21
22	Employee Benefits & Payroll Taxes	(61,397)	7,662	0	0	0	0	0	0	0	0	0	(53,735)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,810	0	0	0	0	0	0	0	0	0	3,810	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(37,155)	1,600	0	0	0	0	0	0	0	0	0	(35,555)	26
27	Other (specify):*	(12,740)	0	0	0	0	0	0	0	0	0	0	(12,740)	27
28	**TOTAL General Administration**	(125,763)	(10,281)	0	0	0	0	0	0	0	0	0	(136,044)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(126,711)	(9,179)	0	0	0	0	0	0	0	0	0	(135,890)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **SunBridge Care & Rehab-Effingham** **#** **0042663** **Report Period Beginning:** **1/1/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	18,521	0	0	0	0	0	0	0	0	0	0	18,521	30
31	Amortization of Pre-Op. & Org.	0	6,531	0	0	0	0	0	0	0	0	0	6,531	31
32	Interest	(282,416)	0	6,628	0	0	0	0	0	0	0	0	(275,788)	32
33	Real Estate Taxes	0	0	334	0	0	0	0	0	0	0	0	334	33
34	Rent-Facility & Grounds	0	0	2,360	0	0	0	0	0	0	0	0	2,360	34
35	Rent-Equipment & Vehicles	0	0	3,471	0	0	0	0	0	0	0	0	3,471	35
36	Other (specify):*	0	7,478	0	0	0	0	0	0	0	0	0	7,478	36
37	**TOTAL Ownership**	(263,895)	14,009	12,793	0	0	0	0	0	0	0	0	(237,093)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(390,606)	4,830	12,793	0	0	0	0	0	0	0	0	(372,983)	45

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SunBridge Healthcare Corp.	100	Please see attached	Please see attached	Please see attached	Please see attached	Please see attached

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	SunBridge Healthcare Corporation	100.00%	$ 712	$ 712	1
2	V	6	Maintenance		SunBridge Healthcare Corporation	100.00%	379	379	2
3	V	14	Program Transportation		SunBridge Healthcare Corporation	100.00%	11	11	3
4	V	17	Administration	108,271	SunBridge Healthcare Corporation	100.00%	3,692	(104,579)	4
5	V	19	Legal and Accounting		SunBridge Healthcare Corporation	100.00%	9,963	9,963	5
6	V	20	Dues & Subscriptions		SunBridge Healthcare Corporation	100.00%	200	200	6
7	V	21	Clerical & General Offices Exp		SunBridge Healthcare Corporation	100.00%	71,063	71,063	7
8	V	22	Employee Benefits		SunBridge Healthcare Corporation	100.00%	7,662	7,662	8
9	V	24	Travel		SunBridge Healthcare Corporation	100.00%	3,810	3,810	9
10	V	26	Insurance		SunBridge Healthcare Corporation	100.00%	1,600	1,600	10
11	V	31	Amortization		SunBridge Healthcare Corporation	100.00%	6,531	6,531	11
12	V	36	Depreciation		SunBridge Healthcare Corporation	100.00%	7,478	7,478	12
13	V								13
14	Total			$ 108,271			$ 113,101	$ * 4,830	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		32	Interest	$	SunBridge Healthcare Corporation	100.00%	$ 6,628	$ 6,628	15
16	V		33	Property Taxes		SunBridge Healthcare Corporation	100.00%	334	334	16
17	V		34	Facility Lease		SunBridge Healthcare Corporation	100.00%	2,360	2,360	17
18	V		35	Equipment Lease		SunBridge Healthcare Corporation	100.00%	3,471	3,471	18
19	V		39	Pharmacy Expense	190,529	Sunscript Pharmacy Corporation		190,529		19
20	V		101	Physical,Speech,Occupational Ther	172,703	Sundance Rehabilitation Corporation		172,703		20
21	V		101	Respiratory Therapy	16,282	Suncare Respiratory		16,282		21
22	V		101	Medical Supplies & Equipment Rental	49,540	Sunchoice Medical Supply		49,540		22
23	V		101	Software	2,891	Sunsystems		2,891		23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 431,945			$ 444,738	$ * 12,793	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Andrew Turner	CEO-Chairman of	Operations	< 1%	534,652	0.062	0.00	Wages	$ 768	17.3	1
2		the Board									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 768		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-3355
Fax Number: (505) 468-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	##########	375	$ 1,894,390	$ 1,894,390	3,380,540	$ 3,669	1
2	5	Heat and Other Utilities	Accumulated Cost	##########	375	341,493		3,380,540	661	2
3	6	Maintenance	Accumulated Cost	##########	375	188,721		3,380,540	365	3
4	14	Program Transportation	Accumulated Cost	##########	375	5,653		3,380,540	11	4
5	19	Legal & Accounting	Accumulated Cost	##########	375	5,096,426		3,380,540	9,870	5
6	20	Dues and Subscriptions	Accumulated Cost	##########	375	97,795		3,380,540	189	6
7	21	General Office Expenses	Accumulated Cost	##########	375	28,601,481	20,782,087	3,380,540	55,391	7
8	22	Employee Benefits	Accumulated Cost	##########	375	3,197,917		3,380,540	6,193	8
9	24	Travel	Accumulated Cost	##########	375	1,138,452		3,380,540	2,205	9
10	26	Insurance	Accumulated Cost	##########	375	821,156		3,380,540	1,590	10
11	30	Depreciation	Accumulated Cost	##########	375	3,836,905		3,380,540	7,431	11
12	31	Amortization	Accumulated Cost	##########	375	3,351,056		3,380,540	6,490	12
13	32	Interest	Accumulated Cost	##########	375	3,401,102		3,380,540	6,587	13
14	33	Property Taxes	Accumulated Cost	##########	375	163,687		3,380,540	317	14
15	34	Facility Lease	Accumulated Cost	##########	375	852,135		3,380,540	1,650	15
16	35	Equipment Lease	Accumulated Cost	##########	375	1,612,216		3,380,540	3,122	16
17										17
18		Total from attached Page 8a	Accumulated Cost	379,321,017	111	1,357,473	931,879	3,380,540	12,098	18
19		Total from attached Page 8b	Accumulated Cost	195,229,250	54	465,270	215,903	3,380,540	8,056	19
20		Total from attached Page 8c	Direct Cost							20
21										21
22			Total Units =							22
23			1,745,570,676							23
24										24
25	TOTALS					$ 56,423,328	$ 23,824,259		$ 125,895	25

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-3355
Fax Number: (505) 468-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	379,321,017	111	$ 1,591	$ 1,591	3,380,540	$ 14	1
2	5	Heat and Other Utilities	Accumulated Cost	379,321,017	111	285		3,380,540	3	2
3	6	Maintenance	Accumulated Cost	379,321,017	111	576		3,380,540	5	3
4	14	Program Transportation	Accumulated Cost	379,321,017	111	4		3,380,540		4
5	19	Legal & Accounting	Accumulated Cost	379,321,017	111	3,367		3,380,540	30	5
6	20	Dues and Subscriptions	Accumulated Cost	379,321,017	111	217		3,380,540	2	6
7	21	General Office Expenses	Accumulated Cost	379,321,017	111	1,130,721	930,288	3,380,540	10,077	7
8	22	Employee Benefits	Accumulated Cost	379,321,017	111	118,303		3,380,540	1,054	8
9	24	Travel	Accumulated Cost	379,321,017	111	65,899		3,380,540	587	9
10	26	Insurance	Accumulated Cost	379,321,017	111	690		3,380,540	6	10
11	30	Depreciation	Accumulated Cost	379,321,017	111	3,222		3,380,540	29	11
12	31	Amortization	Accumulated Cost	379,321,017	111	2,814		3,380,540	25	12
13	32	Interest	Accumulated Cost	379,321,017	111	2,856		3,380,540	25	13
14	33	Property Taxes	Accumulated Cost	379,321,017	111	1,770		3,380,540	16	14
15	34	Facility Lease	Accumulated Cost	379,321,017	111	21,567		3,380,540	192	15
16	35	Equipment Lease	Accumulated Cost	379,321,017	111	3,591		3,380,540	32	16
17										17
18										18
19										19
20			Total Units =							20
21			379,321,017							21
22										22
23										23
24										24
25	TOTALS					$ 1,357,473	$ 931,879		$ 12,097	25

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-3355
Fax Number: (505) 468-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	195,229,250	54	$ 521	$ 520	3,380,540	$ 9	1
2	5	Heat and Other Utilities	Accumulated Cost	195,229,250	54	2,784		3,380,540	48	2
3	6	Maintenance	Accumulated Cost	195,229,250	54	501		3,380,540	9	3
4	14	Program Transportation	Accumulated Cost	195,229,250	54	1		3,380,540		4
5	19	Legal & Accounting	Accumulated Cost	195,229,250	54	3,666		3,380,540	63	5
6	20	Dues and Subscriptions	Accumulated Cost	195,229,250	54	508		3,380,540	9	6
7	21	General Office Expenses	Accumulated Cost	195,229,250	54	323,115	215,383	3,380,540	5,595	7
8	22	Employee Benefits	Accumulated Cost	195,229,250	54	23,964		3,380,540	415	8
9	24	Travel	Accumulated Cost	195,229,250	54	58,819		3,380,540	1,018	9
10	26	Insurance	Accumulated Cost	195,229,250	54	226		3,380,540	4	10
11	30	Depreciation	Accumulated Cost	195,229,250	54	1,055		3,380,540	18	11
12	31	Amortization	Accumulated Cost	195,229,250	54	921		3,380,540	16	12
13	32	Interest	Accumulated Cost	195,229,250	54	935		3,380,540	16	13
14	33	Property Taxes	Accumulated Cost	195,229,250	54	45		3,380,540	1	14
15	34	Facility Lease	Accumulated Cost	195,229,250	54	29,899		3,380,540	518	15
16	35	Equipment Lease	Accumulated Cost	195,229,250	54	18,310		3,380,540	317	16
17										17
18										18
19										19
20			Total Units =							20
21			195,229,250							21
22										22
23										23
24										24
25	TOTALS					$ 465,270	$ 215,903		$ 8,056	25

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-3355
Fax Number: (505) 468-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SunBridge Care & Rehab-Effingham **#** 0042663 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	16,380	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,030	2
3. Under or (over) accrual (line 2 minus line 1).	$	9,650	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,520	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	36,170	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997	25,668	10
1998	25,965	11
1999	26,030	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,754 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11				1991							11
12	TOTALS FROM DEPRECIATION SCHEDULE			2000	142,228	7,397	Various	7,397		14,559	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 142,228	$ 7,397		$ 7,397	$	$ 14,559	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 97,051	$ 13,646	$ 13,646	$		$ 36,738	37
38	Current Year Purchases	9,132	850	850			850	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 106,183	$ 14,496	$ 14,496	$		$ 37,588	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 248,411	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 21,893	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 21,893	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 52,147	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A	120	6/5/97	$ 435,641	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 435,641 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 6/5/1997
Ending 6/30/2007

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 443,173
13.	12/31/2002	$ 455,360
14.	12/31/2003	$ 467,882

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 22,361 Description: Please see attached 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [XX] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a Col 3	hrs	$	3,427	$ 65,964	$ 4,919	3,427	$ 70,883	1
2	Licensed Speech and Language Development Therapist	Line 10a Col 3	hrs		203	10,216	821	203	11,037	2
3	Licensed Recreational Therapist		hrs		11,897	121,667	5,645	11,897	127,312	3
4	Licensed Physical Therapist	Line 10a Col 3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 10 Col 2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Respiratory Therapy & Other (specify): IV Therapy	Line 10a Col 3 Line 10a Col 3			702	2,112	8,277	702	10,389	13
14	TOTAL			$	16,229	$ 199,959	$ 19,662	16,229	$ 219,621	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SunBridge Care & Rehab-Effingham **#** 0042663 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 16,107	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	369,949		3
4	Supply Inventory (priced at)	15,188		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 401,244	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	44,036		15
16	Equipment, at Historical Cost	9,651		16
17	Accumulated Depreciation (book methods)	(3,385)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	255,066		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 305,368	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 706,612	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (55,725)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(62,022)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(185,904)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Accrued Insurance**	(89,752)		36
37	**Gen. Business Tax Payable**	(2,340)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (395,743)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Intercompany**	(2,046,710)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,046,710)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,442,453)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,734,807	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (707,646)	$	48

***(See instructions.)**

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,375,751	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,375,751	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(198,075)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intercompany Eliminations/Bal Sheet Adj.**	557,131	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 359,056	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,734,807	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (3,576,851)	1
2	Discounts and Allowances for all Levels	153,850	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (3,423,001)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(65,951)	6
7	Oxygen	(1,562)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (67,513)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(61,519)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(231)	19
20	Radiology and X-Ray		20
21	Other Medical Services	(19,848)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (81,598)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(114)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (114)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rebates & Refunds/Vending Machine Revenue	(812)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (812)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ (3,573,038)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	530,076	31
32	Health Care	1,545,876	32
33	General Administration	839,670	33
	B. Capital Expense		
34	Ownership	776,676	34
	C. Ancillary Expense		
35	Special Cost Centers	2,901	35
36	Provider Participation Fee	74,880	36
	D. Other Expenses (specify):		
37	Medically Necessary Transportation	1,034	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,771,113	40
41	**Income before Income Taxes (line 30 minus line 40)****	(198,075)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (198,075)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,941	4,124	$ 84,929	$ 20.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,057	18,192	277,190	15.24	3
4	Licensed Practical Nurses	8,970	10,192	124,098	12.18	4
5	Nurse Aides & Orderlies	49,961	51,681	425,535	8.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,632	3,758	37,740	10.04	9
10	Activity Assistants					10
11	Social Service Workers	3,320	3,604	36,207	10.05	11
12	Dietician					12
13	Food Service Supervisor	2,078	2,188	20,843	9.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,543	11,977	78,364	6.54	15
16	Dishwashers					16
17	Maintenance Workers	2,550	2,627	28,379	10.80	17
18	Housekeepers	8,475	8,584	66,428	7.74	18
19	Laundry	4,810	5,069	32,200	6.35	19
20	Administrator	5,986	6,171	97,339	15.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,368	5,092	70,383	13.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,691	133,259	$ 1,379,635 *	$ 10.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	354	$ 12,031	Line 1.3	35
36	Medical Director	Mthly Fee	11,100	Line 9.3	36
37	Medical Records Consultant	Mthly Fee	3,404	Line 10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	92	5,540	Line 10.a.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	454	19,054	Line 10.3	45
46	Other(specify)				46
47	General & Administrative	25	600	Line 15.3	47
48					48
49	TOTAL (lines 35 - 48)	925	$ 51,729		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shirley Dunn	Administrator	None	$ 51,429
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,429

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 108,271
Regional Allocation	80,912
TOTAL (agree to Schedule V, line 17, col. 3)	$ 189,183
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 210
Identicare	New Employee Badges	253
Louis Beis	Medical Records	60
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 523

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,801
Unemployment Compensation Insurance	23,097
FICA Taxes	109,559
Employee Health Insurance	46,387
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Allowance	(44)
Hepatitus B Vacc	625
Other Employee Benefits/PTO Accrual	14,929
Bereavement pay	906
Flex Deductions	(352)
PTO Accrual Adj.	(6,902)
Home Office Allocation	7,662
TOTAL (agree to Schedule V, line 22, col.8)	$ 243,668

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	1,832
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Healthcare Assoc.	5,750
Heaton Publ.\Effingham Daily News	471
Bank Service Charges	646
Regional Office	101
Home Office Allocation	200
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,400

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,253
Regional Travel	7,604
Home Office Travel	3,810
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,667

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SunBridge Care & Rehab-Effingham # 0042663 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association $5,750**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/X** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Arthur Andersen & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Financial Statements are Consilidated**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.